

MALE INCONTINENCE QUESTIONNAIRE

Name:	D.O.B:			
Date:				
1. Are you able to void at the toilet?				
2. Is the urge to void present?				
3. Is there pain or burning when you void?				
4. Is it difficult to start your urine flow?				
5. Do you have a weak stream?				
6. Do you lose urine when you:				
a. Have a strong urge?				
b. See, hear or feel water?				
c. Move from sit to stand?				
d. Lift heavy objects?				
e. Sneeze, cough or laugh?				
f. Walk, run or exercise?				
g. Sleep?				
h. Other?				
7. Do you experience dribbling after voiding?				
8. How many pads/diapers do you use each day?				
9. Are your pads thick or thin?				
10. Are they damp, wet or soaked when changed?				
11. How many times do you get up at night to void?				
12. How many pads do you wear through the night?				
13. Are they damp, wet or soaked when changed?				
14. # Risk factors				
Total Score				
Bladder Diary Findings				
Void Interval				
Void Volume				
Bladder irritants				
Bowel Habits				
Clinician Signature			Date:	
Clinician Signature			Date:	
Clinician Signature			Date:	
Clinician Signature			Date:	

PAST MEDICAL HISTORY



In the past, have you had any serious injuries? Yes No If yes, please list and give dates _____

Please describe below any vehicle accidents or personal injuries in which you have been involved. **(If a pain problem)**

AGE (OR APPROXIMATE YEAR)

- 0 - 10 _____
- 11 - 20 _____
- 21 - 30 _____
- 31 - 40 _____
- 41 - 50 _____
- 50 - 60 _____
- 61 & over _____

Have you had any operations? Yes No If yes, list type of surgeries and dates _____

Do you currently have or have you previously had any of the diseases listed below?

Yes	No		If yes, when diagnosed
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	_____
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes Mellitus	_____
<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	_____
<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	_____
<input type="checkbox"/>	<input type="checkbox"/>	Stomach Disorders (ulcer, etc.)	_____
<input type="checkbox"/>	<input type="checkbox"/>	Liver Disorders (hepatitis, etc.)	_____
<input type="checkbox"/>	<input type="checkbox"/>	HIV Positive	_____
<input type="checkbox"/>	<input type="checkbox"/>	Kidney and Bladder Control	_____
<input type="checkbox"/>	<input type="checkbox"/>	Glands (thyroid, etc.)	_____
<input type="checkbox"/>	<input type="checkbox"/>	Skin Disease	_____
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	_____
<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells	_____
<input type="checkbox"/>	<input type="checkbox"/>	Vision Problems (not glasses)	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hearing Problems	_____
<input type="checkbox"/>	<input type="checkbox"/>	Stroke or TDA	_____
<input type="checkbox"/>	<input type="checkbox"/>	Depression	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other - Please List	_____

Do you have any allergies? Yes No If yes, please list _____

Have you taken cortisone (steroids) by pill within the last 5 years? Yes No

Are you currently taking any medications? Yes No If yes, please list _____

Non-Prescription medications &Supplements? _____

Do you smoke? Yes No If yes, how much? _____